TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
LANCE E. JACKSON, MD

Respondent Name
STANDARD FIRE INSURANCE CO

MFDR Tracking Number
M4-15-2169-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
MARCH 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position summary was not included in the dispute packet.

Amount in Dispute: $1,190.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Claimant's injury was caused by a responsible third party. The Claimant pursued a third party case and received damages from the third party which exceeded the benefit previously paid by the Carrier. Consequently, the Carrier has a credit against future benefits owed, in accordance with Chapter 417 of the Texas Workers Compensation Act, which has not been exhausted…The Claimant is responsible for the medical benefits at issue in this Request for Medical Fee Dispute Resolution."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 27, 2014	CPT Code 99214	$203.14	$0.00
	CPT Code 92504	$71.00	$0.00
	CPT Code 92585	$267.00	$0.00
	CPT Code 92285	$82.40	$0.00
	CPT Code 92540	$177.02	$0.00
	CPT Code 92543	$193.00	$0.00
	CPT Code 92546	$196.46	$0.00

TOTAL		$1,190.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §417.002 outlines the process for recovery in third-party settlements.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16-Code description not given.
   - W1-Code description not given.
   - W3-Code description not given.
   - 309-Charge exceeds fee schedule allowance.

Issues

Is the insurance carrier's reason for denial of payment supported?

Findings

The insurance carrier states that "the Carrier has a credit against future benefits owed, in accordance with Chapter 417 of the Texas Workers Compensation Act, which has not been exhausted."

Texas Labor Code §417.002(a-c), RECOVERY IN THIRD-PARTY ACTION states

> The net amount recovered by a claimant in a third-party action shall be used to reimburse the insurance carrier for benefits, including medical benefits, that have been paid for the compensable injury. (b) Any amount recovered that exceeds the amount of the reimbursement required under Subsection (a) shall be treated as an advance against future benefits, including medical benefits, that the claimant is entitled to receive under this subtitle. (c) If the advance under Subsection (b) is adequate to cover all future benefits, the insurance carrier is not required to resume the payment of benefits. If the advance is insufficient, the insurance carrier shall resume the payment of benefits when the advance is exhausted.

The Division reviewed the submitted documentation and finds:

- No documentation was submitted to refute the carrier's position that the service in dispute are subject to payment from a third-party settlement;
- No documentation was found to support that the net amount recovered in the settlement was exhausted.

The Division concludes that the requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00. The Division emphasized that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. Even though all the evidence was not discussed, it was considered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		07/23/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.